Conclusion: Intestinal injury is a significant complication of laparoscopic colorectal surgery, which can be managed laparoscopically as well as by conversion to open surgery. However, unrecognised injuries can lead to high mortality.

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0912: EVALUATION OF HAEMORRHOID ARTERY LIGATION OPERATION AND RECTO-ANAL REPAIR (HALO-RAR) ON THE TREATMENT OF HAEMORRHOIDS

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Aim: To evaluate the role of HALO-RAR on the surgical management of haemorrhoids by means of pre and post-operative questionnaires.
Method: Patients with grade I-IV haemorrhoids suitable for surgical haemorrhoidectomy were enrolled. A standardized questionnaire was given pre and post-operatively (6 weeks and 12 months) to assess satisfaction and symptom severity. The questionnaire was used to calculate a modified Wexner score. 10-day pain diaries were given postoperatively.
Result: 53 patients were included. By day 10, 6 (15%) patients had a pain score> 4. Preoperatively, the average modified Wexner score was 2.2. At 12 months it was 1.1. After 6 weeks, 72%, 43% and 94% of patients had improvement in pain, pruritus and bleeding respectively. At 12 months, 55%, 45% and 75% had improvement in pain, pruritus and bleeding respectively. 7 patients had recurrence of haemorrhoids.
Conclusion: The majority of the patients felt the core symptoms of pain, pruritus and bleeding were treated successfully. Patients were satisfied with the overall outcome of the procedure. Most patients were discharged on the same day with a low grade of postoperative pain. HALO-RAR seems a safe treatment option with no major peri or post-operative complications. The overall short-term results showed satisfactory symptomatic benefits.

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0929: MINMALLY INVASIVE TREARMENT OF PROLAPSING SYMPTOMATIC HAEMORRHOIDS, RESULTS OF FIRST HUMDRED CASES OF THD-MUCOPEXY

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Introduction: Transanal haemorrhoidal dearterialisation and mucopexy is minimally invasive non-excisional surgery for symptomatic prolapsing haemorrhoids. The long-term results are not clear yet.
Aim: The aim of this study to evaluate long-term outcome of THD-mucopexy.
Method: Prospective data was collected on 100 consecutive cases of grade 3 and 4 symptomatic haemorrhoids between (03/2010 and 06/2015), had THD-mucopexy as day cases under general anaesthetic.
Median follow for two years, average age of 54.4years (range 34 -79), 61% Male and 39% Female.
Result: Pre and postoperative symptoms(6 months) were compared as follow, bleeding preop 74(74%) vs postop 9(9%) ($P < .0001$), prolapse 31(31%) vs postop 7(7%) ($P < 0001$), perianal pain 15(15%) vs 2(2%) ($P = .006$), discharge 5(5%) vs 0% ($P = 0.21$), itching 2(2%) vs 0%($P = 0.47$), anal fissure 4(4%) vs 4(4%) ($P = 0.71$). complication were bleeding 7%, pain 5%, urgency 1%, discharge 2% and fistula 1%. No mortality but recurrence rate was 13%.
Conclusion THD mucopexy is safe and effective minimally invasive modality for prolapsing symptomatic haemorrhoids with acceptable complication rates and a recurrence rate of 13% majority of which could be dealt with a repeat procedure. Long term follow-up and randomised multicentre trials are warranted to compare its efficacy with that of conventional excisional surgery.

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0943: POOR PAIN CONTROL IN MAJOR GASTROINTESTINAL SURGERY

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Aim: Royal College of Anaesthetists standards require that poor pain control should occur on <5% patient days. The aim of the study was to determine the incidence of poor pain control in major gastrointestinal surgery.
Method: Data was extracted from a database where pain scores are recorded at the point-of-care. Patients undergoing bowel resection, reversal of stoma or creation of stoma in 2011-15 were included. Poor pain control was defined as a pain score of 2 or 3 on a 0-3 pain scale.
Result: A total of 1481 patients were included. The initial analgesic strategic was epidural in 692 patients, patient controlled analgesia (PCA) in 601 and oral analgesia alone in 188. Overall 44% experienced early (postoperative days 0-2) poor pain control. Epidural use versus PCA was an independent risk factor for poor pain control (OR 1.59, CI: 1.26-2.02, $p < 0.001$). Early poor pain control was associated with poor pain control on postoperative days 3-5 (OR 2.76, CI: 2.16-3.53, $p < 0.001$).
Conclusion: Poor pain control following major gastrointestinal surgery is common. This observational study cannot fully account for selection bias which may explain increased poor pain control with epidural use. Novel analgesic strategies are required to improve postoperative analgesia in gastrointestinal surgery.

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0947: TELEPHONE ASSESSMENT CLINIC (TAC): A MORE EFFICIENT WAY OF DEALING WITH TWO WEEK WAIT COLORECTAL CANCER REFERRALS

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The 2 week wait (WW) referral pathway is not fit for purpose. 54% of referrals do not meet the referral criteria and nationally the pathway has low diagnostic yield of colorectal cancers (7-10%).
From March to October 2015, a nurse-led Telephone Assessment Clinic was piloted as an alternative to the traditional 2WW pathway. Process and outcome measures were collected prospectively and compared to a representative sample of 2WW pathway patients from the same unit.
38.5% ($n = 240$) of all received 2WW referrals ($n = 624$) were allocated to the TAC. 88% ($n = 211$) were successfully managed on this pathway.
Use of TAC reduced mean time to treatment by 19 days (44 vs 63) and reduced mean time to diagnosis (62 day pathway target) by 25 days (12 vs 37). There were no 62 Day breaches in the TAC cohort compared to 3 breaches in the traditional 2WW pathway. There were 5 cancers detected in the TAC pathway (2%) vs 28 (7%) in the traditional pathway.
There will be a significant increase in numbers of patients referred via the 2WW pathway with a planned expansion of criteria. The TAC pathway provides a more efficient alternative to the traditional 2WW pathway.

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0956: READMISSION TO INDEX VERSUS NON-INDEX PROVIDER AFTER COLORECTAL RESECTION IN THE NHS

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Background: This study aimed to determine whether an association existed between readmission to the same versus different provider after colorectal resection.
Method: Retrospective analysis of hospital episode statistic data from the National Health Service. Adults (18+) undergoing elective or emergency resection of colon or rectum for benign or malignant indication were included. Readmission within 30-days of the initial procedure was recorded, and 90-day mortality taken as the primary endpoint.